USIA EXCHANGE VISITOR ATTESTATION

I, (please print)_____

hereby declare and certify, under penalty of the provisions of 18 U.S.C. 1001, that I do not now have pending, nor am I submitting during the pendency of this request, another request to any United States Government department or agency or any State Department of Public Health, or equivalent, other than the U. S. Department of Agriculture, to act on my behalf in any matter relating to a waiver of my two-year home-country physical-presence requirement.

_____ _____

Signature Date

_____ _____

Notary Date

USIA EMPLOYER ATTESTATION

I, (please print)_____

hereby declare and certify, under penalty of the provisions of 18 U.S.C. 1001, that _____ _____ (medical facility) is located in a rural primary medical care or mental Health Professional Shortage Area and provides medical care to both Medicare and Medicaid-eligible patients and indigent, uninsured patients.

_____ _____

Signature Date

_____ _____

Notary Date

J-1 VISA PHYSICIAN VERIFICATION OF EMPLOYMENT FORM

PHYSICIAN NAME:_____

EMPLOYMENT START DATE: _____

INS J-1 Visa Waiver Approval Date: _____ **H-1(b) Visa Approval Date:** _____

HOME ADDRESS:
Street: _____

City:_____ **State** _____ **Zip Code:** _____

Home Phone: (_____**)**_____

Type of Medical Practice _____

Location of Medical Practice_____
Street

_____ _____ _____ _____
City **County** **State** **Zip Code**

_____
HPSA (include specific County, C.T., CCD, BORO, etc.)

Phone: _____ **FAX:** _____

I HEREBY CERTIFY THAT I, THE UNDERSIGNED, DO PROVIDE PRIMARY HEALTH CARE SERVICES AT THE ABOVE STATED LOCATION(S) A MINIMUM OF 40 HOURS PER WEEK.

_____ _____
Physician's Signature (Notary) **Date**

EMPLOYER/SPONSOR:

I HEREBY CERTIFY THAT DOCTOR_____ **BEGAN**

PRACTICING AT_____ **ON** _____
AND PROVIDES A MINIMUM OF 40 HOURS PER WEEK OF PRIMARY HEALTH CARE IN THE ABOVE LISTED HPSA LOCATION(S).

_____ _____
Employer/Sponsor's Signature (Notary) **Date**

RETURN THIS FORM TO THE FOLLOWING:

MISSISSIPPI STATE DEPARTMENT OF HEALTH
OFFICE OF PRIMARY CARE LIAISON
570 EAST WOODROW WILSON - P. O. BOX 1700
JACKSON, MISSISSIPPI 39215-1700
TELEPHONE #: 601-576-7216
FAX #: 601-576-7230

(Reporting form will be forwarded to the appropriate federal sponsoring agency)

J-1 VISA PHYSICIAN TRANSFER NOTIFICATION FORM

PHYSICIAN NAME:_____

HOME ADDRESS:
Street: _____

City:_____ **State:** _____ **Zip Code:**_____

Home Phone: (_____**)**_____

Sponsor Name: _____

PRESENT LOCATION OF MEDICAL PRACTICE:
Street: _____

City:_____ **State:** _____

County: _____ **HPSA:** _____

Phone: _____

Date of Transfer:_____

Sponsor Name:_____

NEW LOCATION OF MEDICAL PRACTICE:
Street: _____

City:_____ **State:** _____

County: _____ **HPSA:** _____

Phone: _____

I HEREBY CERTIFY THAT I, THE UNDERSIGNED, DO PROVIDE PRIMARY HEALTH CARE SERVICES AT THE NEW LOCATION STATED, A MINIMUM OF 40 HOURS PER WEEK.

_____ _____
Physician's Signature **Date**
(Notary)

I DO HEREBY CERTIFY DOCTOR_____ **BEGAN PRACTICING**

AT_____ **ON** _____**AND PROVIDES PRIMARY**

HEALTH CARE SERVICES AT THE NEW HPSA LOCATION A MINIMUM OF 40 HOURS PER WEEK.

_____ _____
Sponsor Signature **Date**
(Notary)

RETURN THIS FORM TO THE FOLLOWING:

MISSISSIPPI STATE DEPARTMENT OF HEALTH
OFFICE OF PRIMARY CARE LIAISON
570 EAST WOODROW WILSON - P. O. BOX 1700
JACKSON, MISSISSIPPI 39215-1700
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